FY 2002 BUDGET AND PERFORMANCE REQUIREMENTS

June 7, 2001

GENERAL INSTRUCTIONS - ALL CONTRACTORS

FY 2002 BUDGET AND PERFORMANCE REQUIREMENTS
General Instructions (All Contractors)

I. GENERAL DIRECTIONS

General instructions for the preparation of the Budget Request (BR) are contained in HCFA Pub. 13-1 (Fiscal Administration-Intermediaries) and HCFA Pub. 14-1 (Fiscal Administration-Carriers). The Budget Preparation and Budget Execution sections of these manuals have been revised (CR 1393). These manuals were issued on March 27, 2001. Contractors should use the instructions in these manuals when preparing their BR in CAFM II. These Budget and Performance Requirements (BPRs) and the Fiscal Administration manuals specify all forms and accompanying budget documentation narrative that constitute the BR.

Send the BR to the regional office (RO) no later than July 25, 2001. Send 2 informational copies of the budget package to central office (CO) at the following address:

Health Care Financing Administration
Division of Financial Operations, OFM
7500 Security Boulevard
Mailstop C3-13-06
Baltimore, Maryland 21244

NOTE: **DO NOT** mail a hardcopy of ANYTHING that is provided by electronic means to both the RO and CO.

II. INTERNAL CONTROLS

Contractors are required to have acceptable internal controls in place as stated in their contracts with the Government. In the contract, they agree to cooperate with HCFA in the development of procedures to ensure compliance with the Federal Managers Financial Integrity Act (FMFIA). The Comptroller General of the United States prescribes the standards to be followed in order to be in compliance with the intent of FMFIA.

The ultimate responsibility for sound internal controls rests with contractor management. Internal controls should not be looked upon as separate, specialized systems within an organization. Rather, they should be recognized as an integral part of each system that management uses to regulate and guide its operations. Good internal controls are essential to achieving the proper conduct of business with full accountability for the resources made available. They also facilitate the achievement of management objectives by serving as checks and balances against undesired actions. In preventing negative consequences from occurring, internal controls help achieve the positive aims of program managers. A good internal control system includes a risk assessment, proper documentation, and testing of that system. Therefore, it is expected that each contractor have acceptable internal controls to accomplish its operations.

Contractors must demonstrate and certify that they have acceptable internal controls. This requirement is essential to the certification of HCFA's financial statements by the Office of Inspector General and to provide HCFA with knowledge and assurances that contractor operations are complying with HCFA instructions and directions. Contractors are required to certify that they are in compliance with FMFIA. The certification will include disclosure of who reviewed the internal controls, areas reviewed, material weaknesses found, reportable conditions identified, and status of appropriately developed corrective action plans. The certification will be based on a risk assessment, and adequate documentation, as well as testing of internal controls (supported by work papers maintained by the contractor for review by HCFA or appropriate agencies).

As part of your FY 2002 reviews of internal controls you must include a risk assessment review to update

your plans for performing internal control reviews. In addition, in the certification statements due October 15, 2002, contractors must include the contractor identification number, time period of the review; who is in possession of the work papers, and a description of the risk assessment performed to decide on the contractors' areas of risk.

III. CONTRACTOR BUDGET FLEXIBILITY

Contractor budget flexibility refers to each contractor's authority to shift funds within its Notice of Budget Approval (NOBA) once issued. The passage of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes the establishment of the Medicare Integrity Program (MIP). Section 202 of the Act identifies those functions to be funded through MIP and provides separately appropriated funds for them. The remaining contractor functions will be funded through our Program Management (PM) budget.

Program Management (PM)

Contractors may shift funds between PM functions in the Notice of Budget Approval. However, the cumulative amounts shifted to or from any PM function may not exceed 5 percent of the largest approved amount for that function. This flexibility is consistent with the provisions contained in the current fiscal intermediary and carrier contracts.

The following are PM functions:

- Bills/Claims Payment (Intermediary and Carrier);
- Appeals (Intermediary and Carrier);
- Beneficiary Inquiries (Intermediary and Carrier);
- Provider Inquiries (Intermediary and Carrier);
- Provider Education and Training (Intermediary and Carrier);
- Participating Physician (Carrier); and
- Reimbursement (Intermediary).

Productivity Investments (PI): No more than 5 percent may be shifted into or out of PI treated as a whole rather than by separate project.

Special Projects (SP): No more than 5 percent may be shifted into or out of SP treated as a whole rather than by separate project.

Medicare Integrity Program (MIP)

Only the Regional Office Budget and Program Integrity staff may negotiate with the contractor concerning the amount and distribution of MIP funding. Regional Office staff must notify central office immediately should the contractor wish to negotiate a significant increase or decrease in funding and workload.

Contractors may shift funds between MIP functions in the Notice of Budget Approval. However, the cumulative amounts shifted to or from any MIP function may not exceed 5 percent of the largest approved amount for that function. This flexibility is consistent with the provisions contained in the current fiscal intermediary and carrier contracts.

The following are MIP functions:

- Medical Review and Utilization Review (Intermediary and Carrier);
- Medicare Secondary Payer (Intermediary and Carrier);
- Benefit Integrity (Intermediary and Carrier);
- Audit (Intermediary); and

- Provider Education and Training (Intermediary and Carrier).

Productivity Investments (PI): No more than 5 percent may be shifted into or out of PI treated as a whole rather than by separate project.

Special Projects (SP): No more than 5 percent may be shifted into or out of SP treated as a whole rather than by separate project.

Other Budget Flexibility Constraints

- Funding governed by contract modifications may not be shifted.

- The PM and MIP funding represent totally segregated funds which shall not be commingled by the Government or the contractors. Therefore, there is NO flexibility to shift funds between the PM and MIP funds provided. Contractors shall receive separate funding distributions for PM and MIP activities and shall report costs consistent with their budgets, separately identifying PM and MIP activity costs. Funds will continue to be separately accounted for by contractors on the Interim Expenditure Reports and Final Administrative Cost Proposal and funds will be separately disbursed through the Payment Management System (Smartlink).

- Contractor flexibility does not extend to workload and other statement of work issues that must adhere to these BPRs. Statement of work issues also include activities which are required by these BPRs which are not clearly or readily quantifiable as workload.

IV. ADHERENCE TO PERFORMANCE REQUIREMENTS

Contractors are required to adhere to all specific performance requirements stated in these instructions and to explicitly demonstrate compliance with all requirements within any targeted funding levels. Accordingly, all contractors shall include in their requests, the workload and costs associated with each activity stated in the requirements. The requests shall include an explanation and justification for the costs and workload. This information is required even if the information is not specifically requested on the schedule attachments.

NOTE: Do not acquire, or obligate to acquire, additional resources to meet any new requirements as stated in these BPRs until a Program Memorandum or manual issuance providing instructions is issued and until funding has been approved.

You must fully justify each function of the BR. Include the following:

- Justify funding based on the performance requirements stated in the BPRs, but DO NOT restate the BPRs requirements.

- If the performance requirements have not changed from FY 2001, explain how the performance goals will be achieved within currently available funding limits, if applicable.

- If the performance requirements have changed, clearly document and justify any funding change (up or down) associated with the change.

If you comply with the BPRs statement of workload and level of effort, you must include a statement that clearly states compliance with the BPRs. Otherwise, you must state reasons for non-compliance, if applicable.

V. NARRATIVE AND FINANCIAL ANALYSIS REQUIREMENTS

Include a narrative analysis (budget justification) which summarizes the funding and workload requested for each function. The analysis shall provide information as indicated below in addition to any specific information requested in the separate sections for each operation. Operations personnel should actively participate in the development of the BR.

A. WORKLOADS:

- If HCFA workload volumes are supplied and those volumes are acceptable, no volume analysis is required.

- Requests for changes in workload from any HCFA provided volumes must be supported by a volume analysis which includes the historical data used to make the projection, a description of the forecast methodology used and the actual forecast computation. This applies to all activities with identifiable workload volumes.

B. FUNCTION REQUIREMENTS:

- Include any additional information specifically requested in the functional areas of the BPRs.

- Identify and discuss, in total and by function, any material amounts included in the BR that relate to costs of or changes to:

  - Pension plans, including non-qualified plans, as defined by SFAS 87/88 (Employers' Accounting for Pensions/Employers' Accounting for Settlements and Curtailments of Defined Benefit Pension Plans and for Termination Benefits) and;

  - Post-Retirement benefit plans as defined by SFAS 106 (Employers' Accounting for Post-Retirement Benefits Other than Pensions).

  These costs are to be allocated to **EACH** function/activity in your BR and not separately grouped as a PI or Special Project cost.

You must bear the following points in mind as regards the allocation of such costs to the Medicare contract/agreement (see FAR 31.205-6(j), 31.205-6(o), 31.205-19, 28.307-1 and 28.308):

- In order for such pension and/or post-retirement benefit costs to be allowable, they must be <u>funded.</u>

- Any change in accounting practice for such pension and/or post-retirement benefit costs <u>must be submitted to HCFA in advance</u> for approval.

  - Changes in accounting practice include, but are not limited to: a change from cash (pay-as-you-go) accounting to accrual accounting, a change from accrual accounting to cash accounting, a change in actuarial cost method, a change on actuarial asset valuation method, or a change in amortization periods or policy.

- Pension costs are only assignable, and thereby allocable and allowable, if the transition provisions of CAS 412-64 are met and the pension plan is in actuarial balance in accordance with CAS 412-40(c).

- If accrual accounting is elected, the amount of allowable cost for post-retirement benefit

plans is limited to the total cost determined when the ATransition Obligation≅ is computed and amortized according to paragraphs 112 and 113 of SFAS 106.

- If the costs of post-retirement benefits are based on the premiums or other charge for an insurance program maintained by or under the control of the contractor,

  - the program must be submitted to HCFA in advance for approval. A copy of the plan and the underlying actuarial basis for determining the costs or reserves shall be included with your BR.

  - separately identify the insurance program from the remainder of your BR.

C. EXECUTIVE COMPENSATION:

Beginning with 1997, allowable compensation to executives has been limited for purposes of determining government contract costs under the authority of Section 809 of Public Law 104-201. Compensation is defined as Atotal amount of wages, salary, bonuses, deferred compensation, and employer contributions to defined contribution pension plans."

For FY 2001 the statutory provision increased the limit to $374,228 (it was $353,010 for FY 2000, $342,986 for FY 1999, $340,650 for FY 1998 and $250,000 for FY 1997) per year. (See 65 Fed. Reg. 30640.) This amount is the maximum allowable compensation of the 5 highest paid executives at the home office and at each segment of the organization, whether or not the home office or segment reports directly to the contractor's headquarters. This limitation amount applies to contract costs incurred after January 1, 2001.

This $374,228 cap applies to total taxable wages plus elective deferrals before any allocations are applied. For example, if the CEO of ABC company earns an annual salary of $500,000, and the allocation to the Medicare segment is 30%, only $374,228 of the total $500,000 is considered allowable and $112,268 (30% of $374,228) is allocable to Medicare.

Beginning in FY 98, the cap was made permanent by Section 808 of Public Law 105-85. The Administrator of the Office of Federal Procurement Policy (OFPP) sets the ceiling for the allowable amount of executive compensation for 1999, and each succeeding FY (including deferred compensation awards and contributions to defined contribution, e.g., 401(k), pension plans). This amount applies until revised by OFPP.

On March 4, 1999, the Civilian Agency Acquisition Council and the Defense Acquisition Regulations Council issued an interim rule to broaden the definition of "senior executive" found at FAR 31.205-6(p), to clearly include the five most highly compensated employees in management positions at each home office and each segment of the contractor whether or not the home office or segment reports directly to the contractor's headquarters. The interim rule applies to costs of compensation incurred after January 1, 1999, regardless of the date of contract award.

D. GENERAL REQUIREMENTS:

Contractor standard budget and cost accounting methodologies used to develop the BR shall be described and used in your narrative if requested by HCFA.

It is the responsibility of the contractor to fully document and justify the level of funding required for each function and to document compliance with the BPRs. Failure to do so could result in funding not being provided. DO NOT assume from the above that funding will be provided at the current NOBA level. Be prepared to discuss all functions during discussions with the RO.

E. HCFA RO DISCRETION ON DOCUMENTATION NEEDED WITH BR.

The RO has considerable discretion to change the BR documentation requirements for Program Management activities. CAFMII documents must be transmitted in ALL cases. Also the items listed in Section VI must be included with the BR submission. Please contact your RO for instructions on what information they will require with the BR submission.

F. PRODUCTIVITY INVESTMENT (PI)/"SPECIAL PROJECT" COSTS:

Any funds requested for PI and Special Project costs must be fully explained unless they conform to a contract modification such as for Common Working File Host and Maintenance contracts. Cost-benefit ratios, implementation timeframes and the impact on the Medicare operations shall be discussed as appropriate.

VI. ELECTRONIC AND HARD COPY SUBMISSION OF BUDGET REQUESTS

All contractors shall submit their initial FY 2002 BRs and all subsequent supplemental requests to HCFA's mainframe computer no later than the submission date specified using CAFMII. Instructions for transmission are contained in the User's Manual.

DO NOT mail a hardcopy of ANYTHING that is provided by electronic means to both the RO and CO.

Forms transmitted on CAFMII and CASR include:

Activity Forms (With the following attachments as required by HCFA)
- Miscellaneous Schedule
- Special Projects Schedule (if applicable)
- Certification Schedule

Cost Classification Report - HCFA 2580
Contractor Auditing and Settlement Report (A) - HCFA 1525A
Provider Reimbursement Profile (A) - HCFA 1531
Schedule of Providers Serviced (A) - HCFA 1531A

The following MUST be included with your hardcopy BR submission:

- Financial Information Survey (See General Instructions, Section XX)
- Provider/Supplier Service Plan (See Provider Education and Training)
- Medical Review – MR Strategy Report/ Quality Improvement Program Plan (See MR)
- Benefit Integrity - Supporting Documentation (See BI)
- Audit – Supporting Documentation (See Audit)

NOTES:

1. The HCFA-2580 is only required with the initial BR. For the BR, the HCFA-2580 includes the Return on Investment information.

2. Include cost/benefit documentation for Productivity Investments as appropriate with the hardcopy submission.

3. Contractors have been provided with an EXCEL file for the requested audit information. This EXCEL file should be sent electronically to your regional office and Al Bates (abates@cms.hhs.gov) in central office.

4. Contractors should send an electronic version of the MR Strategy Report and the Quality Improvement Program Plan to MROperations@cms.hhs.gov and your regional office.

5. The following is the core listing of required CAFMII activity codes to be used in completing your BR:

INTERMEDIARIES

Program Management

Activity Code	Description
11001	Bills/Claims Processing Ongoing
11006	Provider Enrollment
11061	Systems Security
12001	Part A Reconsiderations
12002	Part A ALJ Hearings
12003	Part B Fair Hearings
12004	Part B ALJ Hearings
12005	Part B Telephone Reviews
12006	Part B Non-Telephone Reviews
13002	Written Inquiries
13003	Walk-In Inquiries
13004	Customer Service Plan
13005	Beneficiary Telephone Inquiries
13014	Beneficiary Quality Call Monitoring
14001	Provider Education and Training
16001	Provider Reimbursement General
17022	Contractor Testing Requirements
33001	Provider Telephone Inquiries

Medicare Integrity Program

Activity Code	Description
21001	MR - Prepay Automated
21002	MR - Prepay Routine Manual
21003	MR - Prepay Complex Manual
21007	MR - Data Analysis
21008	MR - Policy Development
21010	MR – TPL or Demand Bills
21030	MR - Postpay Routine Manual Review
21031	MR - Postpay Complex Manual Provider Specific Review
21032	MR - Postpay Complex Manual Service Specific Review
21100	MR – PSC Support Services
22001	MSP - Prepayment Claims
22002	MSP - Postpayment Claims
22003	MSP - Recoveries from IRS/SSA Data Match
22004	MSP - Inquiries
22005	MSP - Hospital Audits
22006	MSP – Outreach
22021	MSP – DCIA Project
23001	BI - Networking - MFIS
23002	BI - Complaint/Proc/Development
23004	BI - Outreach and Training
23005	BI - Contractor Fraud Dev.
23006	BI - Law Enforcement Support
23007	BI – MR Support of BI Activities
24001	Provider Education and Training
26001	Provider Desk Reviews
26002	Provider Field Audit
26003	Provider Settlements

Miscellaneous

Misc Code	Description
21100/01	Y2K PSC (Y2K)
21100/02	Provider Education (Provider Education)
21100/03	Review of Providers Subject to Corporate Integrity Agreements (CIA)
21100/04	Statistical Analysis Center (SAC)
21100/05	Comprehensive Error Rate Testing Program (CERT)
21100/06	Western Integrity Center (WIC)
21100/07	Therapy Services PSC (TRP)
21031/01	MR-Consent Settlements Offered
21031/02	MR-Consent Settlements Accepted
21031/03	MR-SVRS for Overpayment Estimation
23007/01	BI-Consent Settlements Offered
23007/02	BI-Consent Settlements Accepted
23007/03	BI-SVRS for Overpayment Estimation
51010/01	CFO-Medicare Operations
51010/02	CFO-Preparation and Reconciliation of Financial Forms

51020/01-51020/18	Data Center Costs
51020/01	Adminastar Federal Inc.
51020/03	BCBS Alabama
51020/04	BCBS Arkansas
51020/05	BCBS Kansas
51020/06	CIGNA
51020/07	EDS – Plano
51020/08	EDS – Sacramento
51020/09	Empire BCBS
51020/10	First Coast Service Options
51020/11	Group Health Inc.
51020/12	GTE Data Services
51020/13	Highmark
51020/14	Mutual of Omaha
51020/15	Palmetto (aka BCBS S. Carolina)
51020/16	Regence BCBS Oregon
51020/18	WPS (Wisconsin Physician Services)

CARRIERS

Program Management

Activity Code	Description
11001	Bills/Claims Processing Ongoing
11006	Provider Enrollment
11061	Systems Security
12003	Part B Fair Hearings
12004	Part B ALJ Hearings
12005	Part B Telephone Reviews
12006	Part B Non-Telephone Reviews
13002	Written Inquiries
13003	Walk-In Inquiries
13004	Customer Service Plan
13005	Beneficiary Telephone Inquiries
13014	Beneficiary Quality Call Monitoring
14001	Provider Education and Training
15001	Participating Physician/Suppliers General
17022	Contractor Testing Requirements
33001	Provider Telephone Inquiries

Medicare Integrity Program

Activity Code	Description
21001	MR - Prepay Automated
21002	MR - Prepay Routine Manual
21003	MR - Prepay Complex Manual
21007	MR - Data Analysis
21008	MR - Policy Development
21010	MR – TPL or Demand Bills
21030	MR – Postpay Routine Manual Review
21031	MR – Postpay Complex Manual Provider Specific Review
21032	MR – Postpay Complex Manual Service Specific Review
21100	MR – PSC Support Services
22001	MSP - Prepayment Claims
22002	MSP - Postpayment Claims
22003	MSP - Recoveries from IRS/SSA Data Match
22004	MSP - Inquiries
22005	MSP - Hospital Audits
22006	MSP – Outreach
22021	MSP-DCIA Project
23001	BI - Networking - MFIS
23002	BI - Complaint/Proc/Development
23004	BI - Outreach and Training
23005	BI - Contractor Fraud Dev.
23006	BI - Law Enforcement Support
23007	BI – MR Support of BI Activities
24001	Provider Education and Training

Miscellaneous

Misc Code	Description
21100/01	Y2K PSC (Y2K)
21100/02	Provider Education (Provider Education)
21100/03	Review of Providers Subject to Corporate Integrity Agreements (CIA)
21100/04	Statistical Analysis Center (SAC)
21100/05	Comprehensive Error Rate Testing Program (CERT)
21100/06	Western Integrity Center (WIC)
21100/07	Therapy Services PSC (TRP)
21031/01	MR-Consent Settlements Offered
21031/02	MR-Consent Settlements Accepted
21031/03	MR-SVRS for Overpayment Estimation
23007/01	BI-Consent Settlements Offered
23007/02	BI-Consent Settlements Accepted
23007/03	BI-SVRS for Overpayment Estimation
51010/01	CFO-Medicare Operations
51010/02	CFO-Preparation & Reconciliation of Financial Forms
51020/01-51020/18	Data Center Costs
51020/01	Adminastar Federal Inc.
51020/03	BCBS Alabama
51020/04	BCBS Arkansas
51020/05	BCBS Kansas
51020/06	CIGNA
51020/07	EDS – Plano
51020/08	EDS – Sacramento
51020/09	Empire BCBS
51020/10	First Coast Service Options
51020/11	Group Health Inc.
51020/12	GTE Data Services
51020/13	Highmark
51020/14	Mutual of Omaha
51020/15	Palmetto (aka BCBS S. Carolina)
51020/16	Regence BCBS Oregon
51020/18	WPS (Wisconsin Physician Services)

5. Use the following codes for transmitting cost data if you are a host contractor:

CWF Host-Ongoing:	Code 11002
UPIN Registry (Host only):	Code 11003

6. Use the following codes for transmitting cost data if you are a Shared Maintainer and are paid through a funding conduit:

VIPs Shared Maintenance:	Code 17017
GTE Shared Maintenance:	Code 17019
Arkansas Shared Maintenance:	Code 17020

VII. DURABLE MEDICAL EQUIPMENT REGIONALIZATION (DMERC)

A separate statement of work will be developed for all DMERCs. However, DMERCs must submit BRs on CAFM II consistent with their current scope of work unless a projected scope of work is available. Cost performance targets will be established through these BPRs consistent with the treatment of all other contractors.

VIII. PROVIDER OVERPAYMENTS AND OVERPAYMENT REPORTS

Contractors must maintain timely collection of overpayments. This is a reminder that contractors must aggressively recoup debts from all providers in order to protect the integrity of the Medicare Trust Fund. According to a program memorandum to be issued in the summer of FY 2001, aggressive recoupment efforts include, but are not limited to demanding repayment, recouping from amounts owed the debtor (where appropriate), establishing extending repayment schedules, contacting the debtor via telephone and efforts to locate the debtor when demand letters are returned "undeliverable".

New overpayment and update information must be entered into the POR and PSOR within 10 calendar days; except late filed cost reports, which must be entered into the POR within calendar 17 days. Because both systems are real time systems, it is imperative that timely and accurate information is maintained so HCFA can manage and account for all overpayments. Failure to comply with these reporting requirements compromises the integrity of the overpayment reporting process and constitutes noncompliance with the internal control expectations noted in the FMFIA. (For POR requirements see the Medicare Intermediary Manual, Part 2, Program Administration, Section 2251; for PSOR requirements see the Medicare Carriers Manual, Part 3, Claims Process, Section 13551.) HCFA=s monitoring of entries indicates that some contractors are lax in inputting this data timely.

As a reminder, the contractors are required to include language in demand letters explaining why the provider is liable for overpayments that require Section 1879 and/or Section 1870(b) determinations. If the overpayment determination involves multiple claims, it is necessary to make specific findings under 1879 and/or 1870(b) for each claim at issue. Sample language is provided in the Medicare Carriers Manual, Part 3, Claims Process, Section 7130L, Exhibits III and IV.

Contractors are required to deposit, record and report all unsolicited refunds in accordance with Transmittal Number AB-99-33.

The Debt Collection Improvement Act of 1996 (DCIA) is intended to facilitate collections by the Federal Government and to encourage the streamlining of procedures and coordination of information within and among Federal agencies. The most immediate and obvious impact of the Act, is the requirement that HCFA refer delinquent debt over 180 days delinquent, unless specifically exempted, to Treasury for collection.

Contractors are required to accelerate the referral of eligible delinquent debt to the Debt Collection Center (DCC) and Treasury in accordance with Transmittal Numbers A-01-55 and B-01-31. This accelerated referral will enable HCFA to meet its goal of referring all of its eligible delinquent debt by the end of fiscal year 2002.

Prior to referring delinquent Debt to Treasury, HCFA must obtain certification from Medicare Contractors that the debts selected for referral are valid. This certification process requires the Contractor to validate the amount and status of the debt, accrue interest up to the specified date, and provide notice to the debtor regarding specific information and rights regarding DCIA. This notice, in the form of a demand letter or "letter of intent to refer" allows the debtor 60 days to respond. After 60 days, if the debtor has not responded or repaid the debt, the Medicare Contractor will enter the debt information to the Debt Collection System (DCS) database. This database, developed by HCFA, allows the electronic transfer of debtor information to Treasury for cross servicing. Medicare contractors cease all active collection efforts on the debt, once it is transferred to Treasury. However, the debt is still eligible for internal offset through

the Medicare program and must continue to accrue interest in the contractor system for this purpose. To maintain consistency in the reporting of these debts, any changes to the status, amount due, or other pertinent debtor information must be communicated to HCFA Central Office.

HCFA has encountered cases where the information in the POR/PSOR systems is not current. It is imperative that these systems be maintained accurately and timely. This will prevent the sending of "letters of intent" to providers who have already repaid the debt, are in bankruptcy, or are not the true debtor, etc. The referral of delinquent debt to Treasury for collection is an on-going process. Therefore, it is imperative that contractors validate the debt information maintained in the POR/PSOR systems with debt information maintained in their internal systems prior to entering the debt into the DCS for referral.

IX. COMPLEMENTARY CREDIT RATES

The complementary credit rates are calculated by the Office of Financial Management in accordance with the Medicare Intermediary Manual (Section 1601) and the Medicare Carrier Manual (Section 4601).

The rates for fiscal year 2002 are: Part A $0.69
Part B $0.54

X. CWF HOSTS AND SATELLITES

The current one-year extension to the host site contracts expires on September 30, 2001. Each host site will submit FY 2002 budget requests for host site activities in response to HCFA's request to exercise an option for an additional one-year extension to the existing host contracts.

XI. CONTRACTOR TESTING REQUIREMENTS

HCFA released Change Request #1462, Program Memorandum AB-01-07, on January 19, 2001. This PM provides guidance on testing responsibility for each organization involved in Medicare fee-for-services quarterly systems releases. FIs and carriers are expected to continue to comply with this instruction in FY 2002.

XII. PARTICIPATION IN WORKGROUPS

FIs and carriers are expected to participate in workgroups sanctioned by their respective standard system maintainer change control boards, as well as ad hoc groups formed by HCFA. Participation on the ad hoc groups is not mandatory, but discretionary based on contractor staff availability.

XIII. DATA CENTER COMPENSATING CONTROLS

In those situations where a standard system maintainer releases source code to its data centers, those data centers are expected to establish management controls over Medicare production code, and to exert strict controls over local code that must be used to augment core standard system source code. Program Memorandum, Transmittal AB-01-80, Change Request 1625, issued May 15, 2001, outlines the controls that must be adhered to with respect to the management of production code at all locations, as well as the management of source code as long as it must be distributed.

XIV. CONTRACTOR STANDARD SYSTEMS TRANSITIONS

Migration to the selected Part B standard system will continue into FY 2002.

XV. DATA CENTER COSTS

Contractors are required to provide the projected annual data center costs in their budget request and actual data center costs on the IER and FACP. This cost consists of the charge from the data center to the contractor to support its processing of the standard system (FISS, MCS, APASS, DMERC, VMS-B, HPBSS)) that you use. This would include such items as: the production and testing costs, backups, special runs, hot site testing, and financial and claims processing sub-systems such as RTS, DCIA and PS&R that are integral to processing of claims. It should not include any front end processing that collects claims from providers or any back end functions such as print mail costs.

Report the total amount, not the cost per claim. Note that this should only include the cost of running the standard system, not the entire ADP costs for all Medicare related work. This information should be reported for each data center that a contractor uses. This information should be reported whether you use your own or someone else's data center. Miscellaneous Codes have been assigned in CAFMII for each Data Center. Contractors using the IBM-IGS data center do not have to report this cost information since HCFA contracts directly with IBM for these services.

The costs reported should include processing costs and scheduling and support costs. The following is a description of what these costs should include:

a. Processing costs include the charges billed or the costs allocated to the contractor in compensation for the consumption of data center resources such as CPU, DASD, tapes, etc. Most data centers have a billing algorithm that determines such charges. The billing algorithm should include all hardware, software, staff, facilities, and overhead costs.

b. Scheduling and support costs includes the charges billed or costs allocated to the contractor in compensation for the maintenance and operation of the standard system at the data center. These activities normally are for the labor to maintain the standard system at the data center and install any updates at the data center, to submit and monitor jobs that run at the data center and any special programming that is performed for the contractor associated with standard system functions.

Do not include charges or costs associated with any front end or back end functions such as claims collection at the contractors site, print mail functions, or accounting reconciliation functions.

Enter the total costs for the data center using the following Miscellaneous Codes in CAFMII.

Misc. Code	Data Center
51020/01	Adminastar Federal Inc.
51020/02	(inactive)
51020/03	BCBS Alabama
51020/04	BCBS Arkansas
51020/05	BCBS Kansas
51020/06	CIGNA
51020/07	EDS - Plano
51020/08	EDS - Sacramento
51020/09	Empire BCBS
51020/10	First Coast Service Options
51020/11	Group Health Inc.
51020/12	GTE Data Services
51020/13	Highmark
51020/14	Mutual of Omaha
51020/15	Palmetto (aka BCBS S. Carolina)

51020/16	Regence BCBS Oregon
51020/17	(inactive)
51020/18	WPS (Wisconsin Physician Services)

XVI. USER FEES

HCFA is proposing a number of FY 2002 user fees as a supplemental method of financing the agency=s critical functions. Several of the proposed user fees would need to be implemented by intermediaries and carriers. They include:

- o Charge providers $1.50 for processing a paper claim; and

- o Charge providers who forward duplicate or unprocessable claims $1.50 per claim.

If Congress approves proposed legislation to authorize these fees, HCFA will issue instructions to contractors on how to implement them. This is informational at this time. Do not include a request for funds in your FY 2002 Budget Request or take any actions to implement these fees until advised by HCFA.

XVII. HCFA RETENTION BONUS POLICY STATEMENT

HCFA's policy regarding the payment of retention bonuses paid to employees where the current contract/agreement is not renewed or is terminated was included in a letter to all contractors dated November 15, 2000. That letter clarifies HCFA's policies and procedures regarding the transition and termination or non-renewal costs incurred by a contractor exiting the program and should be reviewed in its entirety.

XVIII. CFO FINANCIAL MANAGEMENT ACTIVITIES

The Chief Financial Officers Act (CFO) of 1990 (P.L.101-576) requires the Health Care Financing Administration (HCFA) to prepare annual, audited financial statements reporting its financial position and results of operations.

Despite audits showing that HCFA is making progress in financial reporting practices, and despite Contractor Performance Evaluations (CPE) reviews conducted by HCFA, as well as reviews and audits performed by the Department of Health and Human Services= Inspector General and the General Accounting Office, independent auditors have identified continuing weaknesses in some Medicare contractors= performance and operations. The 2000 CFO audit continued to identify deficiencies in nearly all aspects of Medicare accounts receivable activity at the contractors sampled by the auditors. While some contractors performed their work appropriately, others were unable to support the beginning balances or could not reconcile their reported ending balances to subsidiary records. The auditors also noted weaknesses in contractors= financial reporting on the HCFA-1522 (Monthly Contractors Financial Report) and in Medicare Electronic Data Processing controls.

For these reasons, we continue to recommend specific financial management activities for the FY 2002 Budget and Performance Requirements. These activities include provisions requiring the establishment of a Chief Financial Officer for Medicare Operations, development and implementation of approved corrective action plans (CAPs) to correct deficiencies identified to contractors, retention of supporting documentation, and reconciliation of HCFA financial reports.

CAFM II Miscellaneous Codes have been established to identify the cost of these activities. Continue to allocate the costs of theses activities to the functions as you have in the past. Report the total costs of these CFO activities using the following Miscellaneous Codes:

a. Chief Financial Officer, (CFO) Medicare Operations should be reported using Miscellaneous Code 51010/01, including costs of activities incurred to support this position, i.e., portion of salaries of administrative/clerical staff dedicated to support the CFO;

b. Preparation and Reconciliation of Financial Reports, and Correction of Deficiencies should be reported using Miscellaneous Code 51010/02.

CHIEF FINANCIAL OFFICER, (CFO) MEDICARE OPERATIONS - (Miscellaneous Code 51010/01)

Medicare contractors must establish a position of Chief Financial Officer, Medicare Operations that is responsible for all Medicare financial reporting and internal controls and reports directly to the Senior Manager, Medicare Operations. We are not requiring that a separate, stand-alone Medicare financial unit be established. Our intent, however, is that the Medicare CFO position be responsible exclusively for Medicare financial operations and not have responsibility for other external third party or corporate activities. Any contractor, who wishes to deviate from this instruction, will contact the Director of the Division of Accounting, Jeff Chaney on (410) 786-7412. The qualification standards for this position must include knowledge of and extensive practical experience in financial management practices in large organizations and significant managerial or other practical involvement relating to financial management. The qualification standards also include an accounting degree from an accredited four-year college or possessing an active Certified Public Accountant (CPA) license, or meeting the eligibility requirements to sit for the CPA examination.

This position will be responsible for all Medicare financial operations including 1) developing control procedures to provide independent checks of the validity, accuracy, completeness and reconciliation of all financial data prior to being reported to HCFA; 2) ensuring and certifying that appropriate Corrective Action Plans (CAPs) are prepared timely and implemented; 3) ensuring that the self-monitoring of internal controls include policies and procedures for prompt resolution of findings identified in Medicare-related audits and other reviews, 4) ensuring that the Provider Overpayment Report (POR) and the Physician/Supplier Overpayment Report (PSOR) is accurate, up-to-date, and reconciled, and 5) validating that all outstanding accounts receivable are supported by appropriate source documents that will be able to withstand independent audit review.

The Medicare CFO will be responsible for certifying the accuracy and completeness of all Medicare-related financial reports including the HCFA-750, HCFA-751, HCFA-1521, HCFA-1522, HCFA-1523, HCFA-1524, and the HCFA-456, that timely reconciliations of financial reports and outstanding checks are performed, and that an effective internal control structure over Medicare financial management operations are in place.

The Medicare CFO is also be responsible for providing HCFA, Office of Financial Management with quarterly reports which provide the status of the contractor's CAP implementation for all financially related deficiencies resulting from CFO audits, contractor performance evaluations, Statement on Auditing Standards (SAS) 70 reviews, as well as other financial audits and reviews performed by consulting/certified public accounting firms, the Office of Inspector General and the General Accounting Office.

The Medicare CFO will be expected to represent your organization at HCFA-sponsored CFO conferences and meetings.

PREPARATION AND RECONCILIATION OF FINANCIAL FORMS, AND CORRECTION OF DEFICIENCIES– (Miscellaneous Code 51010/02)

The Medicare contractor will record all staff time spent on the preparation and reconciliation of HCFA forms 1521, 1522, 456, 750 and 751 according to HCFA instructions in the Medicare Intermediary Manual 1940 and Medicare Carrier Manual 4940. In addition, an April 1998 memorandum from the HCFA CFO requires a monthly reconciliation of paid claims submitted by beneficiaries and providers to the total funds expended on the form HCFA-1522. The monthly reconciliation will be forward to HCFA by the 15th of each month. The reconciliation will include trend analyses that can detect abnormal variations from period to period that must be performed and documented of cash balances, accounts receivable, and accounts payable to identify unusual items that must be investigated and, if appropriate, corrected. Work papers must be prepared, approved by a supervisor, and, along with other supporting documentation, made available to HCFA and auditors upon request.

The lack of an integrated general ledger at the Medicare contractors underscores the need to correctly record and classify accounting transactions, maintain supporting documentation, independently review and validate financial data, and reconcile financial data to detailed subsidiary reports and supporting documentation.

Contractors= internal control structure must provide for documents and records that are adequate to ensure proper recording. Supporting documentation must be available upon request that support data reported on all financial reports.

Additionally, the Medicare contractor will record all staff time spent on the development and implementation of approved CAPs resulting from CFO audits, contractor performance evaluations, Statement on Auditing Standards (SAS) 70 reviews, as well as other financial audits and reviews performed by consulting/certified public accounting firms, the Office of Inspector General and the General Accounting Office. Upon receipt of specific findings resulting from the types of audits/reviews listed above, the Medicare contractor must submit a CAP to HCFA that includes a detailed description of each finding, detailed corrective steps or procedures to be taken to correct the finding, responsible individuals, as well as target and actual completion dates. The CAP should also clarify new or revised procedures for detection and prevention controls that must be implemented to prevent similar types of deficiencies from occurring in the future. The Medicare contractor must also submit quarterly updates/status reports to the CAP, outlining both open and resolved deficiencies so that HCFA can track all findings until completion of the CAP is validated.

XIX. PUBLIC LAW 106-544, MEDICARE, MEDICAID, SCHIP, BENEFIT IMPROVEMENT AND PROTECTION ACT (BIPA)

BIPA has created significant changes in the appeals system for Original Medicare. The statutorily mandated implementation date for the changes in section 521 is October 1, 2002. However, HCFA has requested a one-year deferral for implementing Sections 521 and 522 of BIPA.

- One of the changes made by BIPA is the elimination of the Carrier Fair Hearings and replacing them with decision making authority in an entity the public law refers to as a Qualified Independent Entity (QIC). Another change is to remove the distinction between the process employed to adjudicate Part A and Part B appeals. For instance, all requests for appeals for either Part A or Part B must be made within 120 days of receipt of the initial determination, and appeal action taken by a contractor must be completed within 30 days of the receipt of the appeal request.

As the year progresses, we will provide further information.

XX. FINANCIAL INFORMATION SURVEY ADDENDUM

The Financial Information Survey can be found in Part 1 of the Fiscal Administration Manuals (Section 1255.9 in the Intermediary Manual and Section 4255.9 of the Carrier Manual) and should be submitted as

an integral part of the BR. In addition, please complete the following Addendum to the survey. Include your response and any related supporting documentation as part of your Budget Request.

- Overpayments – Provide the costs associated with the development and resolution/recoupment of overpayments including review and approval of extended repayment plans, and debt referral. Identify the function where the costs are included in your Budget Request (i.e., Claims, Reimbursement, MSP, etc.)

Function	Overpayment Cost	Debt Referral Cost
Bills/Claims Payment		
Appeals		
Beneficiary Inquiries		
Provider Inquiries		
Reimbursement		
Provider Ed and Training		
Participating Physicians		
Medicare Secondary Payer		
Medical Review		
Benefit Integrity		
Audit		
MIP-PET		
TOTAL		